RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

In the event that that short-term rehabilitation exceeds 29 days, the individual must provide proof of his/her resources in order for Medicaid coverage to be established for the rehabilitation services beyond the 29th day. Proof of resources includes resource documentation for prior periods in accordance with transfer of resource policies for nursing facility services (See **RESOURCES** TRANSFER OF ASSETS ALL CATEGORIES) and current resource documentation for CHHA services.

If a recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of a new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. The recipient must complete the "Long-Term Care Change in Need Resource Checklist" and send in the requested resource documentation in order for eligibility to be determined for the requested coverage.

Medicaid A/Rs who attest to the amount of their resources may enroll in a managed care plan, provided the individual is not enrolling in a managed long-term care plan. Participation in a managed long-term care plan requires resource documentation of current resources for care in the community and resource documentation for prior periods in accordance with transfer of resource policies for care in a nursing home. (See **RESOURCES** TRANSFER OF ASSETS ALL CATEGORIES) Once enrolled, the recipient will be eligible for all care and services covered by the plan as well as any wraparound services that are covered under Medicaid fee-for-service.

Attesters who are eligible for Medicaid subject to a spenddown requirement may participate in the Excess Income/Optional Pay-In Program. (See **INCOME** EXCESS and PAY-IN)

Local social services districts may continue to verify the accuracy of the resource information provided by the A/R through collateral investigations. If there is an inconsistency between the information reported by the A/R, and the information obtained by the district is current, the district shall redetermine the recipient's eligibility based on the new

information. If the district requires further information about a particular resource in order to make an eligibility decision, the recipient must be notified to provide the necessary information.

(2) Community Coverage with Community-Based Long-Term Care includes all Medicaid covered care and services except nursing facility services. The coverage does, however, include short-term rehabilitative nursing home care. If a Medicaid A/R elects this coverage, the A/R must provide documentation of his/her current resources.

NOTE: If a Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the A/R is not eligible for short-term rehabilitative nursing home care.

An otherwise eligible individual who fails or refuses to provide adequate resource documentation shall be denied Community Coverage with Community-Based Long-Term Care and shall be authorized for Community Coverage without Long-Term Care if adequate information (not documentation) regarding the individual's resources is provided.

Recipients with Community Coverage with Community-Based Long-Term Care may be enrolled in managed care and managed long-term care.

(3) Medicaid coverage for all covered care and services includes nursing facility services. If a Medicaid A/R elects this coverage, the A/R must be in receipt of nursing home care and provide documentation of his/her resources for the prior periods in accordance with transfer of resource policies . (See **RESOURCES** TRANSFER OF ASSETS ALL CATEGORIES)

RESOURCES

RESOURCE DOCUMENTATION REQUIRED

If a Medicaid A/R does not provide documentation of his/her resources for prior periods in accordance with transfer of resource policies, but does provide current resource documentation, the local district determines eligibility for Community Coverage with Community-Based Long-Term Care. If the A/R provides information on the amount of his/her current resources but does not provide supporting documentation, the district determines eligibility for Community Coverage without Long-Term Care.

Temporary Assistance and Supplemental Security Income (SSI) recipients are authorized for Medicaid coverage for all covered care and services. Individuals who lose SSI eligibility continue to be eligible for Medicaid coverage of all covered care and services until a separate determination is made. (See **CATEGORICAL FACTORS** SEPARATE HEALTH CARE COVERAGE DETERMINATION) Unless the individual's SSI was discontinued due to a prohibited transfer, the individual is not required to provide documentation of his or her resources for the purpose of the ex-parte eligibility determination.

Individuals who are ineligible or lose Temporary Assistance for failure to document resources are referred to Medicaid for a separate determination for Community Coverage without Long-Term Care or Family Health Plus.

Disposition:

Although Medicaid applicants choose a coverage option at application, recipients have the right to supply proof of their resources at any time for a change in coverage. If an individual becomes in need of a service for which he/she does not have coverage, the individual must contact his/her local district immediately for assistance in obtaining the Medicaid coverage required. Medicaid A/Rs who can reasonably expect to need long-term care services are encouraged to provide proof of their resources in advance of the need for such services. This will help prevent any unnecessary delay in service delivery that may result from absence of resource documentation.

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Resource Verification Indicator (RVI) values are used by local districts to identify if a Medicaid recipient:

attested to his/her resources; verified current resources; verified resources for prior periods in accordance with transfer of resource policies; transferred resources; or is exempt from resource verification.

LONG-TERM CARE SERVICES

LONG-TERM CARE		
Community-Based Long-Term Care Services	**Nursing Facility Services**	**Short-Term Rehabilitation Services**
▪ **Adult day health care** ▪ **Assisted living program (ALP)** ▪ **Certified home health agency (CHHA)** ▪ **Hospice in the community** ▪ **Residential treatment facility** ▪ **Managed long-term care in the community** ▪ **Personal care services** ▪ **Waiver and Non-waiver services in the following programs** **a) Long-Term Home Health Care Program** **b) Traumatic Brain Injury Waiver Program** **c) Care at Home Waiver Program** **d) Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program** **e) Nursing Home Transition and Diversion Waiver (NHTD)** ▪ **Consumer directed personal assistance program** ▪ **Limited licensed home care services** ▪ **Personal emergency response services** ▪ **Private duty nursing**	▪ **Alternate level of care provided in a hospital** ▪ **Hospice in a nursing home** ▪ **Nursing home care** ▪ **Intermediate care facility** ▪ **Managed long-term care in a nursing home**	**Once commencement/admission in a 12-month period of up to 29 consecutive days of:** ▪ **Nursing home care** ▪ **Certified home health care**